



Case review

Automatism and driving offences



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ABSTRACT

Automatism is a rarely used defence, but it is particularly used for driving offences because many are strict liability offences. Medical evidence is almost always crucial to argue the defence, and it is important to understand the bars that limit the use of automatism so that the important medical issues can be identified. The issue of prior fault is an important public safeguard to ensure that reasonable precautions are taken to prevent accidents. The total loss of control definition is more problematic, especially with disorders of more gradual onset like hypoglycaemic episodes. In these cases the alternative of 'effective loss of control' would be fairer. This article explores several cases, how the criteria were applied to each, and the types of medical assessment required.

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1. Introduction

Medical automatisms are a narrow range of stereotyped, non-purposeful behaviours typically associated with complex partial seizures. Legal automatism is a state of involuntariness, and exonerates the individual because the criminal justice system only punishes those acting voluntarily. Because it is a denial of the *actus reus*, it is one of the few defences available to a strict liability crime, where no *mens rea* is required. The term 'automatism' was first used in the case of *Harrison-Owen*,¹ although there were cases before that relied on the same principles, with certain caveats, e.g. *Kay v Butterworth*² (see below). Because it is such a powerful defence, there were soon qualifications added. In *Hill v Baxter*³ it was held that there was an evidentiary burden on the defence – that is, the defence must provide sufficient evidence for the defence to be put to the jury (or bench). This nearly always requires medical evidence.^a This need not be evidence to one particular diagnosis (*Lowe*,⁴ *Burton*⁵). The prosecution then has to prove beyond reasonable doubt that the defendant was acting voluntarily, because this is an essential element of any offence (*DPP v Woolmington*).⁶

There have been numerous definitions of automatism which attest to the difficulties in defining the state:

- “total destruction of voluntary control” (Lord Taylor CJ in *Attorney-General's Reference (No2 of 1992)*)⁷;

- “acting involuntarily in the sense that his actions are independent of his will, and therefore not subject to any conscious control” (*Tompkins J in R v Campbell*)⁸;
- “an act which is done by the muscles without any control by the mind such as a spasm, a reflex action or a convulsion; or an act done by a person who is not conscious of what he is doing such as an act done whilst suffering from concussion or whilst sleep-walking” (Lord Denning in *Bratty v. Attorney General for Northern Ireland*)⁹;
- “the mind does not go with what is being done” (Viscount Kilmuir L.C. in *Bratty v. Attorney General for Northern Ireland*);
- “all the deliberative functions of the mind must be absent” (North P. in *R v Burr*)¹⁰;
- “The state of a person who, though capable of action, is not conscious of what he is doing... it means unconscious, involuntary action, and it is a defence because the mind does not go with what is done” (*Bratty v Attorney General for Northern Ireland* [1963] AC 386 per Viscount Kilmuir LC)
- “action without any knowledge of acting, or action with no consciousness of doing what is being done” (*R v Cottle* per Gresson P)¹¹;
- “impairment of relevant capacities as distinct from total deprivation of these capacities (will not suffice) .. It is fundamental to a defence of automatism that the actor has no control over his actions” (*R v Milloy* (1991) per Thomas J).¹²

For policy reasons there are various bars to the defence. The defendant cannot be intoxicated or insane. Voluntary intoxication is only a defence to crimes of specific intent. Insane automatism is a

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^a The case of *Woolley* [1998] CLY 914 is an exception where no medical evidence was required as to the effects of sneezing.

state of automatism where the cause is internal, which comes under the *M'Naghten Rules*.^b This entails a different standard of proof, a different burden of proof, and a different test from sane automatism. There has been debate over whether the insanity defence can be raised for driving offences. This arose from misinterpretation of the 1883 Trial of Lunatics Act and of the Criminal Procedure (Insanity) Act 1964.¹³ In *DPP v Harper* it was held that it was only “available to a defendant in a summary trial only where the offence charged is one in which *mens rea* is an element”.¹⁴ However this interpretation has been disputed, and some commentators consider that the insanity defence covers all offences.^{15,16} Where the insanity defence is raised successfully in the magistrates’ court, it is under the common law doctrine, rather than the statutory special defence introduced the Criminal Lunatics Act 1800. Therefore a simple acquittal results rather than the special verdict of not guilty by reason of insanity. A simple and unintentional mistake does not qualify as an automatism.¹⁷ The bus driver in *Attorney-General’s Reference (No. 4 of 2000)* who pressed the accelerator pedal instead of the brake pedal did not do so intentionally; however, his action in pressing that pedal was intentional and deliberate, and therefore not an automatism. This distinction rests on the difference between ‘intention in acting’ and ‘intentionally acting’.

In a number of cases it has been held that where there has not been a total loss of control, this is not legal (non-insane) automatism. The absence of a total loss of control was the *ratio decidendi* in the cases of *Isitt*¹⁸ and *Attorney-General’s Reference (No. 2 of 1992)*.⁷ In the former case, the accused drove off after an accident and evaded a police road-block. He claimed no memory of the incident – however his actions in driving his vehicle around a police road-block suggesting awareness of his surroundings and full voluntary control. Expert evidence suggested he might have suffered a hysterical fugue. The presence of amnesia, whether due to fugue or not, does not affect criminal liability nor fitness to plead.¹⁹ This is because it is no reflection of the mental state of the accused at the time of the offence. There is a considerable policy element to this decision, given the difficulty in judging the genuineness of amnesia and the frequency of amnesia with alcoholic intoxication. In the latter case, a lorry driver had crashed and his defence was that he was driving without awareness, “a *trance-like state resulting from repetitive stimuli received as a result of driving long journeys on straight, flat, featureless motorways* (p. 91)”. In this state the driver is able to make small course corrections and usually will be aroused by significant stimuli. This preservation of at least some voluntary control precluded the state of legal automatism. It should be noted that the nature of “driving without awareness” is debate by Jim Horne among others.

There is debate over whether this strict approach applies only to driving cases or crimes of strict liability, but there’s nothing in the judgment in *Attorney General’s Reference (No. 2 of 1992)* that restricts the decision to these areas²⁰ (p.709). It could be argued that a better basis for the decisions in these cases would be the *ratio decidendi* in *Rabey*²¹ that

‘the ordinary stresses and disappointments of life which are the common lot of mankind do not constitute an external cause constituting an explanation for a malfunctioning mind which takes it out of the category of a “disease of mind”’.

In neither case was the precipitant extraordinary enough to be considered an ‘external cause’. Contrast *R v T*²² where the trauma was having been raped three days before the robbery, which caused post-traumatic stress disorder (PTSD) and a dissociative episode on the day of the harmful act. This is a reasonable policy-based ground

for differentiating insane from sane automatism, although there follows a problem with distinguishing acute and chronic manifestations of PTSD. Certainly the defendant in *T* could **not be** characterized as having a total loss of voluntary control – she was shouting “I’m ill, I’m ill” as she robbed her victim at knifepoint.

The other major bar to employing the defence is the issue of prior fault. When the person is in a state of automatism, like sleep or a seizure, they are unable to control their actions and prevent, for example, a car accident. The driver in *Kay v Butterworth* was asleep at the wheel when he ploughed into some marching GIs. It was held on appeal that he should be held responsible, because he should have pulled over when he “felt the onset of drowsiness”. Prior fault may be awareness of a condition with which it would be dangerous to drive, ignoring the presence of warning symptoms that should warn the driver to pull over, or contributory negligence or recklessness. It is not clear whether this is an objective or subjective standard. In *Quick*²³ Lawton LJ stated that

“A self-induced incapacity will not excuse[], nor will one which could have been reasonably foreseen as a result of either doing, or omitting to do something, as, for example, taking alcohol against medical advice after using certain prescribed drugs, or failing to have regular meals while taking insulin.”

A risk that “could have been reasonably foreseen” is an **objective** standard conforming to the standards of the reasonable man.

By contrast, in *Bailey*²⁴ it was considered that subjective recklessness was required –

“if **he does appreciate** [emphasis mine] the risk that such a failure [to eat properly following insulin injection] may lead to aggressive, unpredictable and uncontrollable conduct and he nevertheless deliberately runs the risk or otherwise disregards it, this will amount to recklessness” (Griffiths LJ).

A risk that has to be foreseen by the accused is a **subjective** standard. Although recklessness was required in *Bailey*, the lesser standard of negligence may well be sufficient for crimes of strict liability such as most driving offences. I will examine a few examples of how these rules apply to certain medical conditions and some interesting trials.

The disparities between the different definitions of automatism applied in the case law can be explained by the use of automatism to describe a denial of the *mens rea* of the offence. This is technically “unconsciousness” rather than automatism.²⁵ Denial of the *mens rea* is easier to prove than denial of the *actus reus*, and so this is preferred where the crime is not strict liability.

2. Diabetes

According to Professor Vincent Marks, a world-renowned expert witness on hypoglycaemia, in most of the diabetic cases he has been involved in the accused is found guilty on the issue of prior fault.^c There are three main reasons for that. Firstly, that the accused was negligent in their management of their condition. Secondly, that they drove whilst aware of a tendency of sudden onset of hypoglycaemia and/or hypoglycaemic unawareness. Thirdly, that they failed to stop their vehicle either when symptoms of hypoglycaemia occurred or when partial loss of control occurred. These reasons do not hold for every case, as the following example illustrates.

Mr Clarke suffered a hypoglycaemic episode while driving in Birmingham in 2006.²⁶ It was apparent to other drivers and bystanders that something was wrong – he looked “paranoid”,

^b Often styled the *M'Naghten Rules*, but this spelling has been proven incorrect by further analysis of MacNaughtan's signature. *R v McNaughtan* (1843) 8 E R 718.

^c Personal communication.

“fidgety” and “out of it”. He accelerated and braked for no reason, put his windscreen wipers on when there was no need, stopped at a green light and narrowly avoided a collision. He drove like this for over 2 miles, oblivious to other drivers sounding their horns until he finally lost complete control, leaving the road and hitting two step-brothers on the footpath – one aged four years old was killed and the other aged fourteen years old was seriously injured.

Diabetic drivers are usually found guilty on the basis of prior fault. The adrenergic symptoms of sweating, tremor etc normally occur *before* the neuroglycopenic symptoms and signs and so should warn the diabetic driver to pull over. The prosecution expert witness maintained that Mr Clarke would have had some awareness of hypoglycaemia that would have enabled him to avoid the accident. However if the diabetic has hypoglycaemic unawareness like Mr Clarke did, brain dysfunction occurs *before* these symptoms. Therefore where the diabetic driver has *known* hypoglycaemic unawareness, then he is at fault for driving at all – as in *Marison*,²⁷ who was known to suffer sudden onset of hypoglycaemia. This did not apply here as Mr Clarke, living alone, did not have anyone to tell him about these episodes of hypoglycaemia unawareness.

Also the diabetic may mismanage his condition and so increase the likelihood of hypoglycaemia. Again, this was not the case here. Mr Clarke managed his diabetes impeccably. He checked his blood glucose before driving, which was 4.4 mmol/l – so he ate something as per UK driving guidelines.²⁸ The prosecution expert alleged that Mr Clarke's tight control in itself constituted prior fault, because of the predisposition to hypoglycaemic unawareness.

Diabetic drivers also fall foul of the ‘total loss of control’ definition. There have been several similar diabetic driver cases reported where the accused drove for a similar distance to Mr Clarke, and the conclusion of the courts in all these cases was that this was inconsistent with automatism. *Watmore v Jenkins*²⁹ and *Broome v Perkins*³⁰ were both drivers with diabetes who drove erratically for several miles before losing total control. The court held in both instances that at some point the driver must have had sufficient control and awareness of his symptoms to pull over and avoid the accident (therefore also implying an element of prior fault also). This cannot be assumed where the accused suffers hypoglycaemia unawareness and therefore loss of control and insight precedes the adrenergic symptoms.

Mr Clarke drove erratically for over two miles and at one point made a course correction after missing his usual turning. He was also seen to be reaching into the footwell for his glucose tablets. So even if Mr Clarke “proved” he had no warning, the legal definition of automatism precluded the defence. The prosecution argued both of these grounds and at a second trial he was found guilty and sentenced to three years in jail (reduced to one year on appeal).³¹ Unfortunately he fell foul of a lack of understanding about hypoglycaemic unawareness, and the application of the total loss of control definition.

Since the courts haven't formally recognized a case of hypoglycaemic unawareness, it is not known whether this would be a sane or insane automatism (hypoglycaemic unawareness might arguably be an internal cause). The diagnosis of hypoglycaemia unawareness is made by performing continuous glucose monitoring to see how many episodes of hypoglycaemia occur concurrently with reported symptoms, over 3 days or more. This monitoring is widely available in the NHS. An insulin challenge test would document a lack of the usual adrenergic response to hypoglycaemia, but this is not the test expert witnesses would rely on^d as it does not record the person's responses in daily life.

Interestingly, in the civil case of *Mansfield v Weetabix*³² a lorry driver who suffered hypoglycaemia (in this case from an

insulinoma) was not held liable for crashing into a house even though he had been stopped earlier that day by the police for a driving offence and was apparently hypoglycaemic at that time.

If a driver is known to have hypoglycaemia unawareness, then he will found liable on the basis of prior fault, since he is driving in the knowledge of a dangerous condition (*Marison*).²⁷ Although it is recommended that diabetics check their blood glucose before driving, failure to do so is not considered negligent or prior fault (*R v JG*).³³

3. Sleep apnoea

In *Kay v Butterworth*² it was established that even when the accused was asleep at the time of the offence, he could be held liable through prior fault in continuing to drive after he had ‘felt the onset of drowsiness’. This assumes that the driver has warning that he might fall asleep at the wheel, an assumption that continues to be held for policy reasons as much as anything. Horne reports that 16–20% of incidents on major roads are sleep-related.³⁴

Despite the excessive daytime sleepiness (EDS) that occurs with obstructive sleep apnoea/hypopnoea syndrome (OSAHS), there have been a number of acquittals for driving offences where the accused claimed to be unaware of his condition. In *Thomas* (unreported, Maidstone Crown Court in 2011), the prosecution offered no evidence on a charge of causing death by dangerous driving when it was found he had undiagnosed sleep apnoea.³⁵ Certainly where the individual is aware of OSAHS, then he will be found liable on the basis of prior fault. In any case, since this is an internal cause so if the accused is acquitted it should be on the basis of the insanity defence.

There has been no ruling on whether falling asleep at the wheel with no warning in a sleep-deprived individual would still constitute prior fault or not, on the grounds of driving in a dangerous condition (sleep deprivation). A recent study found that even in healthy sleep-deprived volunteers, there is not always warning prior to falling asleep.³⁶ In contrast, Professor Jim Horne found that

“people who fall asleep at the wheel are aware that they are doing so at the time, but that for plausible reasons, they will subsequently not recall being sleepy, even though at the time they would have done things to keep themselves awake (e.g. allowing cold air onto the face or turning up the radio)”³⁷

This is a view supported by the majority of the literature.^{38–41}

It seems unlikely that in cases of moderate to severe sleep apnoea, the accused would not be aware there was something wrong, even if they did not recognize the severity of their condition – and so on policy grounds it is more appropriate that most of these individuals be found guilty of what is a strict liability offence. One study reported that almost 10% of HGV drivers had symptoms of suspected undiagnosed OSAHS. HGV drivers were found to have an increased prevalence of risk factors of OSAHS. The study also found that even when successfully treated, OSAHS sufferers were especially sensitive to sleep deprivation.⁴²

A sleep-related incident should be considered where:

- There is no other explanation e.g. mechanical defects, alcohol, bad weather, speeding or tail-gating.
- The point of impact could be seen for at least 7 s prior to the incident (pointing to at least a micro-sleep)
- Additional pointers are a dull road (hence the association with motorway travel) and the incident occurring between 0200–0600 and 1400–1600 h³⁴

As noted above, drivers often will not remember being sleepy or falling asleep, so a denial of either state should not rule out a sleep-related incident, no matter how genuine it is. Evidence of measures

^d Personal communication from Professor Tony Barnett, diabetologist.

to fight sleep is more reliable (cold air via vents or window, music turned up).

The assessment of sleep apnoea requires referral for video-polysomnography and multiple sleep latency tests or, more appropriately, maintenance of wakefulness tests. The latter is considered more directly relevant to driving as it is conducted in conditions close to driving. In severe sleep apnoea the apnoea/hypopnoea index (AHI- the total number of episodes of apnoea and hypopnoea divided by the number of hours of sleep) should be greater than 30/hour (figures courtesy of Dr Chris Idzikowski). The usefulness of the AHI is disputed⁴³ and there are several other measures e.g. the Respiratory Disturbance Index (RDI - average number per sleep hour of apnoeas, hypopnoeas, and respiratory effort-related arousals), Oxygen Desaturation Index (ODI - the average number of significant oxygen desaturations per hour of sleep) and arousal index (number of EEG arousals per hour). Sleepiness is usually assessed by the Epworth Sleepiness Scale, those scoring over 12 having EDS (normal average score is 5).⁴⁴ The test that is most applicable to driving is the maintenance of wakefulness test.

Even though 21 h sleep deprivation causes psychomotor impairment equivalent to being over the drink drive limit,⁴⁵ there are no specific offences in the UK relating to driving whilst sleep deprived. New Jersey has a law on 'drowsy driving', known as 'Maggie's Law'. Driving whilst fatigued (defined as 24 h sleep deprivation or more) is an offence. Any deaths resulting from such a state may be classified as vehicular homicide.

4. Epilepsy

Epilepsy is usually of sudden onset with no warning and a total loss of control, thus it is easily characterised as an automatism. Complex partial seizures might potentially pose a legal problem, since it might be argued that there was not a total loss of control. However the driver who gets behind the wheel when it is clear that he shouldn't be driving will be held liable for prior fault and his condition will be an exacerbating factor in sentencing, as per *Sims*⁴⁶ who had presumed epilepsy and had been warned not to drive. One study noted that of eight driving incidents reported in the press as due to epilepsy, five drivers were not previously known to have epilepsy.⁴⁷ This may well not be a representative cross-section, since cases where the diagnosis of epilepsy was in doubt would be more newsworthy.

Non-adherence to treatment should be considered. Inadequate anti-epileptic treatment can also be due to the accused deliberately concealing the severity of their condition.⁴⁸ Tiredness and alcohol consumption are not factors considered contributory to epileptic seizures.⁴⁹

5. Sleepwalking/sleepdriving

Sleepdriving is well recognized, and when it occurs after alcohol intake may lead to charges of drink-driving. It is uncontroversial that sleepwalking is a cause of automatism (even though sleepdriving and other sleepwalking activities are inconsistent with the total loss of control definition), but in the Scottish case of *Finegan v Heywood*⁵⁰ where the accused knew that drinking triggered his sleepwalking and sleepdriving he was found guilty of drink-driving on the basis of a "self-inflicted condition". In the English case of *Pooley*, it was reported that Judge Tyrer directed the jury that if the trigger for the sleepwalking was alcohol, Pooley should be found guilty.⁵¹

The diagnosis of sleepwalking is clinical although video-polysomnography can be supportive. Alcohol is generally recognized to trigger sleepwalking in a small proportion of sleepwalkers, although it is more likely to reduce sleepwalking or have no effect.

The Alcohol Provocation Test has been used by some experts⁴ but is unvalidated and has been criticised heavily by some experts.

6. Multiple sclerosis

Reginald Pull, who suffers from multiple sclerosis, was found not guilty by reason of insanity of causing death by dangerous driving.⁵² His multiple sclerosis caused leg spasms which resulted in a loss of control of his vehicle. This pre-existing condition would have constituted prior fault but for the effect of multiple sclerosis on his insight into his disability – thus the finding of insanity.

7. Conclusion

There are a number of medical conditions that may be a defence to driving offences, but the law restricts the defence of automatism partly because of the implications for public safety. The main bars are prior fault and the requirement for total loss of control. It is entirely appropriate that reasonable precautions are taken to prevent serious accidents occurring. Although the patient has the ultimate responsibility for informing the DVLA about any conditions of concern, medical practitioners should counsel patients as to when this is necessary. HGV drivers due to a combination of diet and physical inactivity are particularly prone to obstructive sleep apnoea, and the medical practitioner should be aware of this possibility given the success of medical treatment which means that the driver will not automatically lose his license. Whereas in criminal cases it may be that subjective recklessness is required, probably objective recklessness is the appropriate standard for driving cases.

The bars to the defence of automatism will have major implications for an accused with these conditions, and so it is important that the forensic practitioner understand the appropriate tests that may be required. This is especially true where hypoglycaemic unawareness may be a possibility, where continuous glucose monitoring will demonstrate hypoglycaemic episodes of which the person is unaware. In these cases it can be argued persuasively that there was no element of prior fault. It is also important to emphasize to the court that persons suffering from amnesia will tend to confabulate, and this is not an indication of a malicious intent to deceive in these circumstances. The total loss of control definition is problematic, but the Law Commission are currently looking at the area of insanity and automatism and so it may be that much-needed reform will occur and the alternative definition of 'effective loss of control' adopted (as recommended in the Law Commission's Draft Criminal Code pp 57–8⁵³).

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Conflict of interest

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